FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022541

Facility Name: Continental Care Center

Address: 5336 N. Western Ave (Number) Chicago (City) 60625 (Zip Code)

County: Cook

Telephone Number: (773) 271-5600 **Fax #** (773) 271-2144

IDPA ID Number: 362871756001

Date of Initial License for Current Owners: 00/0076

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Marvin Fox, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	208	Skilled (SNF)	208	75,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	208	TOTALS	208	75,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,288	2,763	4,064	33,115	8
9	SNF/PED					9
10	ICF	14,883	117		15,000	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,171	2,880	4,064	48,115	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.38%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2,147

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	249,912	23,085	8,284	281,281		281,281		281,281			1
2	Food Purchase		186,506		186,506	(24,528)	161,978	(111)	161,867			2
3	Housekeeping	178,248	35,727		213,975		213,975		213,975			3
4	Laundry	51,547	25,917		77,464		77,464		77,464			4
5	Heat and Other Utilities			176,482	176,482		176,482		176,482			5
6	Maintenance	71,453		91,669	163,122		163,122	(7,788)	155,334			6
7	Other (specify):*											7
8	**TOTAL General Services**	551,160	271,235	276,435	1,098,830	(24,528)	1,074,302	(7,899)	1,066,403			8
	B. Health Care and Programs											
9	Medical Director			19,000	19,000		19,000		19,000			9
10	Nursing and Medical Records	1,791,856	88,987	3,432	1,884,275		1,884,275		1,884,275			10
10a	Therapy	53,477		17,536	71,013		71,013		71,013			10a
11	Activities	104,134	6,287	4,503	114,924		114,924		114,924			11
12	Social Services	59,913		2,498	62,411		62,411		62,411			12
13	Nurse Aide Training											13
14	Program Transportation			705	705		705		705			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,009,380	95,274	47,674	2,152,328		2,152,328		2,152,328			16
	C. General Administration											
17	Administrative	84,178		311,000	395,178		395,178		395,178			17
18	Directors Fees											18
19	Professional Services			80,625	80,625		80,625		80,625			19
20	Dues, Fees, Subscriptions & Promotions			55,727	55,727		55,727	(39,980)	15,747			20
21	Clerical & General Office Expenses	101,318	38,189	406,892	546,399		546,399	(354,991)	191,408			21
22	Employee Benefits & Payroll Taxes			567,687	567,687	24,528	592,215		592,215			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,584	2,584		2,584	(1,071)	1,513			24
25	Other Admin. Staff Transportation			6,258	6,258		6,258		6,258			25
26	Insurance-Prop.Liab.Malpractice			273,270	273,270		273,270		273,270			26
27	Other (specify):*											27
28	**TOTAL General Administration**	185,496	38,189	1,704,043	1,927,728	24,528	1,952,256	(396,042)	1,556,214			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,746,036	404,698	2,028,152	5,178,886		5,178,886	(403,941)	4,774,945			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Continental Care Center #0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			177,477	177,477		177,477	399	177,876			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			201,965	201,965		201,965	(156,909)	45,056			32
33	Real Estate Taxes			254,495	254,495		254,495		254,495			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,815	9,815		9,815		9,815			35
36	Other (specify):*											36
37	**TOTAL Ownership**			643,752	643,752		643,752	(156,510)	487,242			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		195,881	213,572	409,453		409,453		409,453			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,880	113,880		113,880		113,880			42
43	Other (specify):*	19,697		828	20,525		20,525	(25,347)	(4,822)			43
44	**TOTAL Special Cost Centers**	19,697	195,881	328,280	543,858		543,858	(25,347)	518,511			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,765,733	600,579	3,000,184	6,366,496		6,366,496	(585,798)	5,780,698			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	399	30		9
10	Interest and Other Investment Income	(156,909)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(111)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,317)	21		18
19	Entertainment	(1,071)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(347,195)	21		24
25	Fund Raising, Advertising and Promotional	(39,310)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,337)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(670)	20		28
29	Other-Attach Schedule	(37,277)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (585,798)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (585,798)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Continental Care Center

ID# 0022541

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (24,519)	43	1
2	Bank Charges	(1,726)	21	2
3	Use Tax	(2,416)	21	3
4	Capitalized R&M	(7,708)	06	4
5	Marketing Auto and Travel	(828)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(37,277)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Continental Care Center # 0022541 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(111)											(111)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(7,788)											(7,788)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(7,899)											(7,899)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services													19
20	Fees, Subscriptions & Promotions	(39,980)											(39,980)	20
21	Clerical & General Office Expenses	(354,991)											(354,991)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,071)											(1,071)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(396,042)											(396,042)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(403,941)											(403,941)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Continental Care Center # 0022541 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	399											399	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(156,909)											(156,909)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(156,510)											(156,510)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(25,347)											(25,347)	43
44	**TOTAL Special Cost Centers**	(25,347)											(25,347)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(585,798)											(585,798)	45

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		None		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Meisels	Owner	Administrative	20.00%	See Attached	8.00	20.00%	Mgmt Fees	$ 60,000	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 60,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
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4										4
5										5
6										6
7										7
8										8
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

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1						$	$		$	1
2										2
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6										6
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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Street Address
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1						$	$		$	1
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9										9
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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4										4
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7										7
8										8
9										9
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
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Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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7										7
8										8
9										9
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American Charter Bank		X	Mortgage	Varies	10/27/01	$ 3,650,000	$ 3,107,021	01/01/07	Prime+1.5	$ 164,505	1
2	Viasys/Bird		X	Equipment Purchase	$2,006.00	05/09/01		70,477	04/09/06			2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank Financial		X	Line of Credit				1,467,024	2/1/04	4.50%	45,092	6
7	DVI		X	Line of Credit							(7,852)	7
8	See Supplemental Schedule										220	8
9	TOTAL Facility Related				$2,006.00		$ 3,650,000	$ 4,644,522			$ 201,965	9
	B. Non-Facility Related*											
10												10
11	Interest Income		X								(156,909)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (156,909)	14
15	TOTALS (line 9+line14)						$ 3,650,000	$ 4,644,522			$ 45,056	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10	Insurance		X	Insurance Financing							220	10
11												11
12												12
13												13
14	TOTAL Working Capital										220	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	268,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	260,095	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,305)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	262,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	254,495	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	248,551	8
	1999	246,883	9
	2000	250,691	10
	2001	257,211	11
	2002	260,095	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2003 Accrual 260,095 X 1.01 = 262,800

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Continental Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0022541

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-226-006-0000	Long Term Care Property	$ 225,092.38	$ 225,092.38
2.	13-12-226-007-0000	Long Term Care Property	$ 30,515.95	$ 30,515.95
3.	13-12-226-018-0000	Long Term Care Property	$ 4,486.71	$ 4,486.71
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 260,095.04	$ 260,095.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Continental Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0022541

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,288 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	108,000	1976	$ 356,000	1
2					2
3	TOTALS	108,000		$ 356,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1976	$ 2,130,000	$ 60,857		$ 60,857	$	$ 1,430,121	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	6,105		20	-		6,105	9
10	Various			1980	9,032		20	-		9,032	10
11	Various			1983	19,029		20	-		19,029	11
12	Various			1985	24,698		20	985	(985)	20,659	12
13	Various			1986	43,755		20	2,188	2,188	33,253	13
14	Various			1987	31,019		20	245	245	29,667	14
15	Various			1988	12,294		20	137	137	11,448	15
16	Various			1989	27,060		20	985	985	20,259	16
17	Various			1991	19,303		20	965	965	11,969	17
18	Various			1992	2,934		20	-		2,931	18
19	Various			1993	11,866		20	594	594	6,392	19
20	Various			1994	38,563		20	2,094	2,094	19,751	20
21	Various			1995	54,419		20	2,721	2,721	24,503	21
22	Various			1996	65,777		20	2,962	2,962	22,049	22
23	Various			1997	16,158		20	808	808	5,124	23
24	Various			1998	180,933		20	9,047	9,047	49,433	24
25	Various			1999	78,906		20	3,947	3,947	18,430	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			116,620			(116,620)		69
70	TOTAL (lines 4 thru 69)		$ 2,771,851	$ 177,477		$ 88,535	$ (90,912)	$ 1,740,155	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,771,851	$ 177,477		$ 88,535	$ (88,942)	$ 1,740,155	1
2	Fire Dampers	2000	31,000		20	795	795	3,147	2
3	Electrical Wiring	2000	6,272		20	161	161	637	3
4	25 Doors	2000	3,942		20	454	454	3,261	4
5	Electric Wiring	2000	798		20	20	20	79	5
6	Ii Access Doors	2000	1,986		20	229	229	1,643	6
7	Electric Wiring	2000	1,695		20	43	43	153	7
8	Fence	2000	511		20	39	39	158	8
9	Install Breaker	2000	2,832		20	73	73	251	9
10	Fire Guard Tank	2000	6,381		20	164	164	580	10
11	Push Button Locks	2000	583		20	67	67	482	11
12	Electric Wiring	2000	12,475		20	320	320	1,053	12
13	Electric Transfer	2000	11,246		20	288	288	925	13
14	Fuel Tank	2000	2,462		20	152	152	587	14
15	Install Mirror	2000	1,957		20	225	225	1,619	15
16	Rehab Room	2000	1,392		20	36	36	115	16
17	Electric Rehab Room	2000	1,650		20	42	42	132	17
18	Wiring Kitchen	2000	769		20	20	20	62	18
19	Install Phones	2000	743		20	37	37	111	19
20	Painting & Decoratin	2000	1,284		20	64	64	192	20
21	Blinds	2000	662		20	33	33	99	21
22	Boiler Heat Exchng	2000	4,950		20	248	248	743	22
23	Replace Sprinkler Sy	2001	825		20	41	41	124	23
24	Fire Alarm Panel	2001	995		20	50	50	150	24
25	Plumbing	2001	778		20	39	39	117	25
26	Install Phone Lines	2001	1,171		20	59	59	166	26
27	Exhaust System	2001	2,500		20	125	125	354	27
28	Electrical Outlets	2001	775		20	39	39	107	28
29	Fire Doors Inst.	2001	970		20	49	49	130	29
30	Heat Exchanger	2001	4,950		20	248	248	660	30
31	Boiler Pipe Inst.	2001	1,120		20	56	56	149	31
32	Chain Link Fence	2001	988		20	49	49	132	32
33	Fire Dampers Install	2001	2,908		20	145	145	364	33
34	TOTAL (lines 1 thru 33)		$ 2,885,421	$ 177,477		$ 92,945	$ (84,532)	$ 1,758,637	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,885,421	$ 177,477		$ 92,945	$ (84,532)	$ 1,758,637	1
2	Rewire Pump Motor	2001	1,598		20	80	80	167	2
3	Replace Exhaust Moto	2001	1,087		20	54	54	114	3
4	Electrical Wiring	2001	1,496		20	75	75	156	4
5	Rooftop Exhaust	2001	609		20	30	30	76	5
6	Refrigerator Work	2001	508		20	25	25	61	6
7	Wrought Iron Fence	2001	980		20	49	49	123	7
8	Ejector Pump Parts	2001	1,968		20	98	98	238	8
9	Fire Alarm Parts	2001	513		20	26	26	60	9
10	Life Alarm	2001	1,962		20	98	98	237	10
11	Valve Work	2001	909		20	45	45	99	11
12	Custom Draperies	2001	1,919		20	96	96	200	12
13	Life Alarm Keyboard	2001	1,394		20	70	70	145	13
14	Install Telephone Wiring	2002	3,435		20	344	344	573	14
15	Remove And Replace Cooling Tower	2002	17,900		20	1,790	1,790	2,983	15
16	Install Duct Work/ Fire Dampers	2002	650		20	65	65	108	16
17	Remove And Install Carpet	2002	16,641		20	2,377	2,377	3,962	17
18	Install Intercom System	2002	800		20	114	114	190	18
19	Concrete Work To Repair Parking Lot	2002	4,435		20	222	222	425	19
20	Install Duct Detectors Per Idph Report	2002	9,450		20	945	945	1,181	20
21	Concrete Work To Repair Parking Lot	2002	4,025		20	201	201	252	21
22	Remodeling	2002	12,000		20	1,200	1,200	1,400	22
23	Quarry Tile Installation	2002	1,867		20	124	124	145	23
24	Exterior Fixtures	2002	1,731		20	173	173	216	24
25	Air Conditioners	2002	573		20	82	82	116	25
26	Generator	2002	1,584		20	79	79	158	26
27	Pipes	2002	1,128		20	113	113	207	27
28	Chiller	2002	960		20	96	96	168	28
29	Sink Lines	2002	1,687		20	169	169	267	29
30	Fire Pump	2002	1,095		20	156	156	248	30
31	Call System	2002	990		20	66	66	99	31
32	Outdoor Lamps	2002	1,366		20	137	137	182	32
33	Phone Cables	2002	525		20	53	53	66	33
34	TOTAL (lines 1 thru 33)		$ 2,983,206	$ 177,477		$ 102,197	$ (75,280)	$ 1,773,259	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,983,206	$ 177,477		$ 102,197	$ (75,280)	$ 1,773,259	1
2	Fan Motor	2002	1,100		20	110	110	119	2
3	Painting & Decorating	2002	7,112		20	8,235	8,235	8,984	3
4	Heavy-Duty Passage Levers	2003	3,092		20	180	180	180	4
5	Fire System Meter	2003	1,337		20	78	78	78	5
6	Cubicle Curtains And Window Treatments*	2003	5,614		20	374	374	374	6
7	Tile And Carpet In Lobby Area*	2003	9,588		20	154	154	154	7
8	Wallpaper	2003	2,000		20	400	400	400	8
9	Gfi Recepticle/Elec. Wiring	2003	743		20	37	37	37	9
10	Chiller Maint.	2003	860		20	43	43	43	10
11	Cooling Tower Motor	2003	875		20	44	44	44	11
12	Magnetic Doors/Smoke Det	2003	741		20	37	37	37	12
13	Wrought Iron Fence	2003	860		20	43	43	43	13
14	Wall Repair	2003	780		20	39	39	39	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,908	$ 177,477		$ 111,971	$ (65,506)	$ 1,783,791	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 628,415	$	$ 62,966	$ 62,966	10	$ 451,159	71
72	Current Year Purchases	26,110		2,939	2,939	10	2,939	72
73	Fully Depreciated Assets	544,595				10	544,595	73
74								74
75	TOTALS	$ 1,199,120	$	$ 65,905	$ 65,905		$ 998,693	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1982 FORD	1982	$ 14,556	$	$	$	5	$ 12,000	76
77		1986 VAN	1986	15,916				5	15,916	77
78		USED VAN	1988	3,000				5	3,000	78
79										79
80	TOTALS			$ 33,472	$	$	$		$ 30,916	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,606,500	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 177,477	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 177,876	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 399	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,813,400	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 9,815 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 81,664	$		$ 81,664	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			35,213			35,213	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			96,695			96,695	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				102,032		102,032	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						93,849		93,849	13
14	TOTAL			$		$ 213,572	$ 195,881		$ 409,453	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 174,697	$	1
2	Cash-Patient Deposits	51,923		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,781,304		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,248		6
7	Other Prepaid Expenses	232		7
8	Accounts Receivable (owners or related parties)	3,274,707		8
9	Other(specify): See Attached Schedule	281,991		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,619,102	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	486,000		13
14	Buildings, at Historical Cost	2,130,000		14
15	Leasehold Improvements, at Historical Cost	697,026		15
16	Equipment, at Historical Cost	1,371,364		16
17	Accumulated Depreciation (book methods)	(2,837,960)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	21,700		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	9,565		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	245,140		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,122,835	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,741,937	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,294,092	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,923		28
29	Short-Term Notes Payable	1,467,024		29
30	Accrued Salaries Payable	95,920		30
31	Accrued Taxes Payable (excluding real estate taxes)	(9,570)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	262,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	226		35
	Other Current Liabilities(specify):			
36	See Attached Schedule	27,726		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,190,141	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	70,477		39
40	Mortgage Payable	3,107,021		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,177,498	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,367,639	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,374,298	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,741,937	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,015,311	1
2	Restatements (describe):		2
3	See Attached	369,325	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,384,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	89,662	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (10,338)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,374,298	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,920,318	1
2	Discounts and Allowances for all Levels	(486,465)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,433,853	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	707,466	6
7	Oxygen	14,271	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 721,737	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	84,434	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,942	19
20	Radiology and X-Ray	1,380	20
21	Other Medical Services	48,903	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 143,659	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	156,909	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 156,909	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,456,158	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,098,830	31
32	Health Care	2,152,328	32
33	General Administration	1,927,728	33
	B. Capital Expense		
34	Ownership	643,752	34
	C. Ancillary Expense		
35	Special Cost Centers	429,978	35
36	Provider Participation Fee	113,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,366,496	40
41	**Income before Income Taxes (line 30 minus line 40)****	89,662	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 89,662	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,985	2,121	$ 68,234	$ 32.17	1
2	Assistant Director of Nursing	1,993	2,075	57,162	27.55	2
3	Registered Nurses	29,112	31,234	740,911	23.72	3
4	Licensed Practical Nurses	9,556	9,872	208,255	21.10	4
5	Nurse Aides & Orderlies	72,148	77,130	679,460	8.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,527	4,990	53,477	10.72	8
9	Activity Director	1,926	2,091	26,016	12.44	9
10	Activity Assistants	8,881	9,711	78,118	8.04	10
11	Social Service Workers	4,017	4,587	59,913	13.06	11
12	Dietician					12
13	Food Service Supervisor	2,025	2,168	34,827	16.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,677	26,291	215,085	8.18	15
16	Dishwashers					16
17	Maintenance Workers	3,372	3,710	71,453	19.26	17
18	Housekeepers	23,076	24,382	178,248	7.31	18
19	Laundry	6,111	6,890	51,547	7.48	19
20	Administrator	1,822	2,250	84,178	37.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,531	7,097	101,318	14.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,834	3,083	37,834	12.27	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,060	1,109	19,697	17.76	33
34	TOTAL (lines 1 - 33)	204,653	220,791	$ 2,765,733 *	$ 12.53	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 8,284	01-03	35
36	Medical Director	320	19,000	09-03	36
37	Medical Records Consultant	80	3,432	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	360	17,536	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	4,503	11-03	44
45	Social Service Consultant	37	2,498	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,045	$ 55,253		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carole Considine (4/1-12/31/03)	Administrator	0	$ 56,307
William Pfeiffer (1/1-3/18/03)	Administrator	0	27,871
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,178

B. Administrative - Other

Description	Amount
David Meisels	$ 60,000
Olympia Healthcare Management Fees	251,000
Olympia Healthcare owners are not related to owners of Continental Care Center.	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 311,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consult	$ 2,625
FR&R	Accounting	11,856
Bank Financial	Accounting	1,510
Winston & Strawn	Legal	14,987
Sachnoff & Weaver	Legal	6,781
Quality Care Management	Computer Services	2,000
HDSI	Computer Services	7,797
Accu-Med	Computer Services	2,446
KIPP Computer Solutions	Computer Services	750
Parallax Tech. Services	Computer Services	2,690
L&A Computer Service	Computer Services	630
See Supplemetal Schedule		26,553
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 80,625

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,866
Unemployment Compensation Insurance	40,213
FICA Taxes	211,579
Employee Health Insurance	197,082
Employee Meals	24,528
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	8,959
Head Tax	5,752
401K Expense	2,944
Union Pension	20,583
Life Insurance/Disability	9,976
Misc. Employee Benefits	8,733
TOTAL (agree to Schedule V, line 22, col.8)	$ 592,215

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,751
Health Care Worker Background Check	156
(Indicate # of checks performed 13)	
Dues & Subscriptions	5,089
Licenses & Permits	5,751
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,747

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,513
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,513

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Continental Care Center # 0022541 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Continental Care Center # 0022541 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $4,940**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,898** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **113,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,528** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.